

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore M.D.

02991

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County... Howard

City or town... Ellicott City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Carlton Carter

4. Sex  5. Color or race C 6. (a) Single, married, widowed, or divorced

m

c

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) June 8, 1897 6. (c) If alive, give age years

8. AGE: Years 47 Months 8 Days 27 If less than one day

9. Birthplace... Simpsonville Md. (Town, county, and state)

10. Usual occupation... Laborer

11. Industry or business

12. Name... Mrs. W. T. Carter

13. Birthplace... Md.

14. Maiden name... Josephine Dorsey

15. Birthplace... Md.

16. Informant... Mrs. Josephine Carter

Address... Ellicott City Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof... 3-8-45

Cemetery or crematory... Hopkins Chapel

Location... Highland Md

18. Funeral director... J. P. H. Whitham

Address... Ellicott City Md.

19. March 7 1945 John B. Vaughan  
(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md

County... Howard

City or town... Ellicott City

(If outside city or town limits, write RURAL and give nearest town)

Street No... Frederick Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH... March 5- 1945 at 230 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

2-27-45 1945 to 3-5-45 1945

and that I last saw him alive on 3-5-45

Immediate cause of death...

Fibrosis of lung  
(Non-Tuberculosis.)

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations...

Date of op. /

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

23. SIGNATURE...

M. D. or other

Address... Calverville, Md. Date signed... 3/5/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

02992

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County... Howard  
 City or town... Sunset City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Clarke Witch4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Purcell M. Witch7. Birth date of deceased (mo., day, yr.) Jan. 18, 1872 6. (c) If alive, give age ..... years8. AGE: Years 73 Months 1 Days 23 If less than one day hrs. ..... min.9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation At home

## 11. Industry or business

12. Name James Beckenridge Clarke13. Birthplace md.14. Maiden name Aura J. Kennedy15. Birthplace md.16. Informant John M. WitchAddress Sunset City md.17. Burial Burial Date thereof 3-14-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. JohnsLocation Sunset City md.18. Funeral director J.C. Wiggins BrothersAddress Sunset City md.19. March 14, 1945 John B. Longman  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard  
 City or town Sunset City  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No. main St  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number None

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 11, 1945 at 3:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 5, 1945 to March 11, 1945  
 and that I last saw her alive on March 11, 1945

Immediate cause of death.....

Generalized arteriosclerosis

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work? .....

23. SIGNATURE.....

John B. Longman, M.D.  
 Address Sunset City Date signed 3/14/45





145-1/2 Corkscrew

162 1/2 Returnee

169 8 alt



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 32

62994

## CERTIFICATE OF DEATH

Reg. Dist. No. 195

## 1. PLACE OF DEATH:

County Howard

City or town Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

8. AGE:

Years Months Days If less than one day hrs. min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date record by registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County Howard

City or town

Savage Rd

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

March 7<sup>th</sup> 1945 at 9<sup>30</sup> A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1<sup>st</sup> 1944 to March 7<sup>th</sup> 1945and that I last saw her alive on March 7<sup>th</sup> 1945

Immediate cause of death Myocardial Insuff.

Duration 6 hours

Due to

Hypertension

Due to

Arteriosclerosis

Other conditions

Senility

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

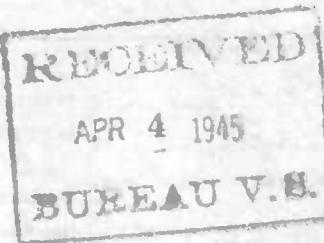
Injured at work?

23. SIGNATURE

Frank Shiley, M.D.

M.D. or other

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

02995

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

## 1. PLACE OF DEATH:

County..... Howard  
City or town..... Glenelg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

John David Karp

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

widower

6.(b) Name of husband or wife

Josephine E. Karp

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Dec. 13 1862

8. AGE:

Years  
92Months  
3Days  
14If less than one day  
hrs. min.

9. Birthplace

Frederick Co. Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name..... Daniel Karp

13. Birthplace..... Md.

MOTHER FATHER

14. Maiden name..... unknown

15. Birthplace..... Md.

16. Informant

Mrs. Marcella Howard

Address

Glenelg, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof..... Mar. 30, 1945  
(month) (day) (year)

Cemetery or crematory..... Mt. View

Location..... Alpha, Md.

18. Funeral director..... F.C. Karp &amp; Son

Address..... Elliott City, Md.

19. Mar. 29 1945  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Howard

City or town..... Glenelg  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... March 27 1945 et 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 1945 to March 27 1945

and that I last saw him alive on March 26 1945

Immediate cause of death.....

Arteriosclerotic cardiovascular  
heart disease

DURATION

?

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury.....

Injured at work? .....

23. SIGNATURE.....

John Karpian, M.D.

M. D. or other

Address..... Elliott City, Md. Date signed..... Apr. 1/45

RECEIVED BY THE STATE DEPARTMENT

STATE DEPARTMENT

RECORDED IN CABLEGRAM REGISTER

RECORDED IN INDEX

HOLY CROSS, JAPAN

RECEIVED

MAY 5 1945

BUREAU V.S.

T

PLEASE WRITE PLAINLY, WITH UPPADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 478

## CERTIFICATE OF DEATH

02996

Reg. Dist. No. 194

## 1. PLACE OF DEATH:

County HowardCity or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

No hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Daisy W Hobbs

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

FW.married6.(b) Name of husband or wife Chas. W. Hobbs

6.(c) If alive, give age years

7. Birth date of deceased (mo. day, yr.)

July 20, 1890

8. AGE:

Years

Months

Days

If less than one day

5483

hrs. .... min.

9. Birthplace Hagerstown md.

(Town, county, and state)

10. Usual occupation at home

11. Industry or business

Unknown12. Name Unknown13. Birthplace ..14. Maiden name ..15. Birthplace ..16. Informant Mrs. Gardner ShippAddress 714 Frederick Rd. Catonsville, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 3-26-45  
(month) (day) (year)Cemetery or crematory Cathedral ChapelLocation Clarksville, 2nd18. Funeral director J.C. KirschbaumAddress Eurotta City Md19. rec'd by registrar SA Nichols  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State  Maryland County HowardCity or town Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_ (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 23 1945 at 2 PM M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-00 1944 to 3-22 1945and that I last saw her alive on 3-22 1945

Immediate cause of death

Carcinoma of Lungs

DURATION

1 1/2 yrsDue to Carcinoma Mediastinal Gland2 yrsDue to Arricular Fibrillation3 mo

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

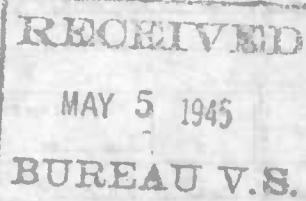
23. SIGNATURE George Ed. Baer MD

M. D. or other

Address 803 3rd Ave Date signed 3-23-45Catonsville 28 Md.

RECEIVED BY THE STATE GUARDIAN

BOARD TO STAFFED



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1642

02997

## CERTIFICATE OF DEATH

Reg. Dist. No. 194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:  
 County ..... Howard  
 City or town ..... Dayton  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Russell O Hobbs

4. Sex m 5. Color or race w 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Margaret O Hobbs

7. Birth date of deceased (mo., day, yr.) Aug. 18, 1911 8. (c) If alive, give age ..... years

8. AGE: Years 33 Months 6 Days 14 If less than one day  
 hrs. ..... min.

9. Birthplace Dayton Md.  
 (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

12. Name Samuel D Hobbs

13. Birthplace md.

14. Maiden name Mary Stevens

15. Birthplace md.

16. Informant Mrs. C. L. Hobbs

Address Dayton Md.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 3-5-45  
 (month) (day) (year)

Cemetery or crematory Linthicum Chapel

Location Clarksburg, Md.

18. Funeral director F.C. Nequinbotham

Address Ellis St City Md.

19. (a) - 4 (Date rec'd by registrar) 19. M.D. - S.A. Nachod  
 (Date signed) 3/2/45

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)

State Md County Howard

City or town Dayton  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

3. (b) Social Security Number \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH 3/2 1945 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

3/2 1945, to 3/2 1945, and that I last saw h. 1m alive on no date 19

Immediate cause of death Gunsight wound in head in fronted region instant

DURATION none

Due to none

Other conditions none

(Include pregnancy within 8 months of death)

Major findings or operations none Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 3/2/45

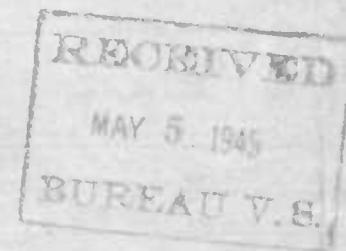
Where did injury occur? Dayton Howard Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury gunshot - self inflicted Injured at work? no

23. SIGNATURE George E. Burdorf MD M. D. or other

Address Ellis St City Md. Date signed 3/2/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Bd*

## CERTIFICATE OF DEATH

Reg. Dist. No. *193*

1. PLACE OF DEATH: *Howard*  
County.....

City or town..... *near Dairy*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

4. Sex *M* 5. Color or race *W* 6. (a) Single, married, widowed, or divorced *Widowed.*

6. (b) Name of husband or wife *Ela May Junkin*

7. Birth date of deceased (mo., day, yr.) *Jan. 8, 1873* 6. (c) If alive, give age ..... years

8. AGE: Years *72* Months *2* Days *11* If less than one day ..... hrs. ..... min.

9. Birthplace *Pa.* (Town, county, and state)

10. Usual occupation *Farmer*

11. Industry or business *Henry Junkin*

FATHER 12. Name *Henry Junkin*  
13. Birthplace *Ohio*

MOTHER 14. Maiden name *Emily Shiley*  
15. Birthplace *Carroll Co., Md.*

16. Informant *Raymond Junkin*

Address *Woodbine and*

17. Burial *Burial* Date thereof *March 22, 1945*  
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory *Mt. Carmel*

Location *near Sunshine Mont. Cr.*

18. Funeral director *H. M. Snyder*

Address *Mt. airy and.*

19. Mar. 21, 1945 *Mar. 21, 1945* (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town..... (If outside city or town limits, write RURAL and give nearest town)

Street No..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH *March 19, 1945* 19..... at ..... M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *March 17, 1945*, to *Mar. 19, 1945*and that I last saw him alive on *March 18, 1945* 19.....Immediate cause of death *Gangrene both feet and legs* DURATION *3 wks*Due to *Arterio-sclerosis* ?Due to *Chr. Myocarditis* ?Other conditions *none* Date of op. ....

(Include pregnancy within 8 months of death)

Major findings of operations *none* Date of op. ....Autopsy results *none* Date of op. ....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

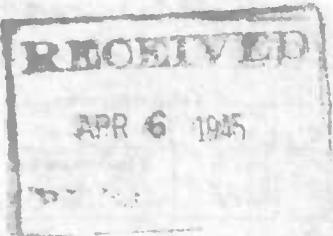
Accident, suicide, or homicide Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE *Stanley Grubell* M. D. or other *Dr. Grubell*Address *Worthington, Md.* Date signed *3/20/45*



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 109

62999

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County

Howard

City or town

Ellicott City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife

Genevieve P.

McKibben

B. (c) If alive, give age

years

7. Birth date of deceased (mo. day, yr.)

June 5, 1882

8. AGE:

Years Months Days If less than one day  
62 9 — hrs. min.

9. Birthplace

Kenosha Ohio

(Town, county, and state)

10. Usual occupation

Radio repair

11. Industry or business

Westinghouse

12. Name

Justin H. Day McKibben

13. Birthplace

Kenosha Ohio

14. Maiden name

Ella Day

15. Birthplace

Kenosha Ohio

16. Informant

Mrs. Genevieve P. McKibben

Address

Montgomery Road Ellicott City

Burial

Date thereof May 8, 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

St. Johns Cemetery

Location

Ellicott City, Md

18. Funeral director

Easton Sons

Address

608 Frederick Ave Catonsville, Md.

Death rec'd by registrar

Dy 8 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Ellicott City

(If outside city or town limits, write RURAL and give nearest town)

Street No. Montgomery Road

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (b) Social Security Number

217-16-0066

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Mar 5, 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 3, 1945, to March 5, 1945

and that I last saw him alive on March 5, 1945

Immediate cause of death

Vasore pneumonia

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

P

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

P

Date of

Where did injury occur

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

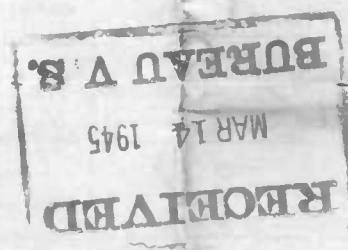
P

Injured at work

23. SIGNATURE

S. Lloyd Johnson M. D. or other

Address Catonsville Date signed 3-7-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

PD

## CERTIFICATE OF DEATH

Reg. Dist. No. 131911

## 1. PLACE OF DEATH:

County... BaltimoreCity or town... Ellwood City Rural  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Ready4. Sex m 5. Color or race c 6. (a) Single, married, widowed or divorced widowed6. (b) Name of husband or wife Angerous Ready7. Birth date of deceased (mo., day, yr.) Aug. 1847 8. (c) If alive, give age years8. AGE: Years 97 Months  Days  If less than one day   
hrs.  min. 9. Birthplace North Carolina  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

12. Name W.W. Ready13. Birthplace N.C.14. Maiden name unknown15. Birthplace "16. Informant Mrs. Mrs. Reg. exec.Address Ellwood City Md.17. Buried Buried Date thereof 4-3-1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Pine OrchardLocation Pine Orchard Md.18. Funeral director F.C. Higham & SonsAddress Ellwood City Md.19. 4-3-1945 John B. Longham  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... Ellwood City Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No... Waterson Road  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH March 31 1945 at 10 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3/1/45 to 3/31/45and that I last saw him alive on 3/31/45 1945Immediate cause of death Arteriosclerotic Cardio-Vascular Disease DURATION 5 yrs.

Due to.....

Due to.....

Other conditions none (Include pregnancy within 8 months of death)Major findings of operations none Date of op. ....Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury..... Injured at work? .....

23. SIGNATURE George E. Baugher Jr. M. D. or other MDAddress Ellwood City Md. Date signed 3/31/45

